

No. 2
4-13-40
5-17-39
I X2315

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **5682**
Registrar's No. **1930**

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

St. Louis, Mo.

- (a) County.....
(b) City or town.....
(c) Name of hospital or institution **City Sanitarium**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **About 10 years**
(Specify whether years, months or days)
In this community.....

3. (a) PRINT FULLNAME **HAZEL WALLER**

3. (b) If veteran, name war **No** 3. (c) Social Security No **No**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Separated**
6. (b) Name of husband or wife **Nathan Waller** 6. (c) Age of husband or wife if alive **unk** years
7. Birth date of deceased **July 13, 1904**
(Month) (Day) (Year)

8. AGE: Years **36** Months **6** Days **30** If less than one day
.....hr.min.

9. Birthplace **Birmingham Alabama**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housework**

11. Industry or business

MOTHER FATHER { 12. Name **Unknown**
13. Birthplace **Unknown** 9
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown** 8
(City, town, or county) (State or foreign country)

16. (a) Informant **Dr. J. L. Smith**
(b) Address **5400 Central St.**

17. (a) (b) Date thereof **2-18-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington**

18. (a) Signature of funeral director **W. R. R. R. R.**
(b) Address **5400 Central**

19. (a) **FEB 28 1941** (b) **J. F. R. R. R.**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Missouri** (b) County **17**
(c) City or town **St. Louis** 9 11
(If outside city or town limits, write "RURAL")
(d) Street No. **1720 Coleman**
(If rural, give location) 0
(e) If foreign born, how long in U. S. A.? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **12**
year **1941** hour **2:45** minute **A.** M.

21. I hereby certify that I attended the deceased from **7-1-39**, 19, to **2-12-41**, 19;
that I last saw h. **her** alive on **2-12-41**, 19;
and that death occurred on the date and hour stated above.
Immediate cause of death **G.P.I. 7-40x**

Due to.....

Due to.....

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy..... No. **12**

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) Means of injury **0**

23. Signature **N. J. R. R. R.** (M. D. or other)
Address **5400 Central** Date signed.....

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.